STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
310 Great Circle Road
NASHVILLE, TENNESSEE 37243-1700

MCC CHECKLIST

Instate and Out-Of-State Individual Provider In Private Practice or Provider Joining A Group

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following

NPI Number _ _ _ _ _ _ _ _ _ _

NPI Collection Form _____

No. 2 Group Application _____

Disclosure Of Ownership _____

Substitute W-9 Form _____

Copy Of License _____

Copy Of License Renewal _____

Copy of Certification _____

Copy of Renewal _____

NOTE: THIS FORM MUST BE RETURNED WITH THE ENROLLMENT PACKET

Bureau of TennCare/Medicaid
Provider Enrollment

310 Great Circle Road
Nashville, TN 37243-1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 2 INDIVIDUAL APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

Complete Name: _____ **Title:** _____
(As Shown on License) **(M.D., D.D.S., etc.)**

(Check All That Apply)	_____ **Change of Ownership**
_____ **New Enrollment**	_____ **Reactivation**
_____ **MCC Medicaid No.**	_____ **Adding Practice/Satellite Location**
_____ **Medicare/Medicaid No.**	_____ **Name Change and Tax ID # Change**
Practice Location Address (No P. O. Box #)	**Pay-To Name & Address** (as shown on the I.R.S. and W-9 Form)
Street: _____	**Legal IRS Name:** _____
City: _____	**Name (cont'd)** _____
County: _____	**D/B/A Name:** _____
State: _____	**Street:** _____
Zip Code + 4: _____	**City:** _____
Telephone #: _____	**State:** _____
Fax Number: _____	**Zip Code + 4:** _____
	Telephone #: _____

Federal Tax No. (IRS No.): _____ **Social Security No. (req'd):** _____

Federal Medicare No.: _____ **State Medicaid No.:** _____ **NPI No.:** _____

Medical Specialty: _____

Taxonomy: _____, _____, _____, _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Board-Certified (Y/N): _____ **Board-Eligible (Y/N):** _____

Name of Board: _____ **DEA No.:** _____

Certificate No.: _____ **Date of Issuance:** _____
Month / Day / Year

Hospital-Affiliated (Y/N): _____ **Hospital-Based (Y/N):** _____

Name of Hospital: _____

Submit copies of professional licenses, and/or certifications, specifically required to operate as a health care provider.

State License No.: _____ **Date Of Issuance:** _____
Month / Day / Year

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper ,if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Provider's Original Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

If you belong to a group and authorize all monies due be made payable to the group, please indicate the name and provider number of said group and sign below.

_____ _____

Group Name **Medicare Group Provider No.**

Provider's Original Signature: _____ **Date:** _____

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All Title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

GENERAL INSTRUCTIONS

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	-42CFR 51A.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-42CFR 228.72-73

Please answer all questions as of the current date. If the "yes" space for any item is checked, list requested additional information under the Remarks Section on page 5, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original to the State agency and retain a copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

(b) **For Regional Office Use Only.** If the "yes" space is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III – List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock in the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity, (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity or the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Item IV - VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under the applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the "yes" space is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V – If the answer is yes, list the name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI – If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII – A chain affiliate is any free-standing health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII – If yes, list the actual number of beds in the facility now and the previous number.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of Entity	D/B/A	Provider #	Telephone #

Street Address	City, County, State	Zip Code

II. Answer the following "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 5. Identify each item number to be continued

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes _____ No _____

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes _____ No _____

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months?

Yes _____ No _____

III. **(a)** List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 5. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity:

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Unincorporated Associations
- ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EIN's for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If "Yes", list names, addresses of individuals and provider numbers.

_____ Yes _____ No

Name	Address	Provider Number

IV. **(a)** Has there been a change in ownership or control within the last year? _____ Yes _____ No
If Yes, give date: _____

(b) Do you anticipate any change of ownership or control within the year? _____ Yes _____ No
If Yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? _____ Yes _____ No
If Yes, when? _____

V. Is this facility operated by a management company, or leased in whole or part by another organization?

_____Yes _____No

If Yes, give date of change in operations: _____

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?

_____Yes _____No

VII. **(a)** Is this facility chain affiliated? (If Yes, list name, address of Corporation, and EIN)

_____Yes _____No

Name: _____ EIN # : _____

Address: _____

VII. (b) If the answer to Question VII.a. is "No", was the facility ever affiliated with a chain?

_____Yes _____No

Name: _____ EIN # : _____

Address: _____

VIII Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?

If "Yes", give year of change: _____ Current beds: _____ Prior beds: _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF IT'S AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed): Title:

Signature: Date:

Remarks

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-5 above, fill in your Social Security Number

   __ __ __ - __ __ - __ __ __ __

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   __ __ - __ __ __ __ __ __ __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

National Provider Identifier (NPI) Collection Form
(Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information
(Please make additional copies if required)

Provider Last Name	First Name	Middle	Title

Existing Medicaid ID's	SSN	EIN Number

Section 2 – NPI Information

NPI Number _____

Taxonomy Codes

Section 3 – Primary Practice Location (As Entered on NPPES)

Address _____

City	State	ZIP

Phone Number	Fax Number	Provider e-mail Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number	Fax Number	Contact e-mail Address

Signature _____ **Title** _____

NPI Collection Form Surety Statement:
"I certify that the information provided on this application is complete and correct to the best of my knowledge."

Instructions
Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 248-4386 or (866) 456-8059
Field	**Instruction**
Section 1 – Provider General Information	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
Section 2 – NPI Information	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.